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STATE OF DELAWARE
DEPARTMENT OF STATE
DIVISION OF PROFESSIONAL REGULATION

TELEPHONE: (302) 744-4500
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APPLICATION FOR A LICENSE TO PRACTICE AS A PHYSICIAN ASSISTANT IN THE STATE OF DELAWARE

I am applying for licensure by the following method:

_____Initial (Never having been licensed)

_____Endorsement/Reciprocity

_____Reinstatement

SECTION I: PERSONAL INFORMATION

Name: _____
(Last Name) (First Name) (Middle/Maiden)

Mailing Address: _____

_____
(City) (State) (Zip Code)

Daytime Telephone: (____)_____ Email _____

Date of Birth: _____ Social Security Number: _____

SECTION II: EDUCATION / CERTIFICATION / LICENSURE AND PERMITS

1. Are you a graduate of an AMA approved PA program? Yes ( ) No ( )
   If yes, please indicate name and address of institution:

   _____ Date of Graduation:

   _____ _____

   _____

2. Have you ever been deemed ineligible to sit for a PA national certifying examination for any reason? Yes ( ) No ( )
   If yes, please provide an explanation on a separate sheet and attach it to this application.

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that the disclosure of your social security number on this application is required by 29 *Del. C.* §8807(m). It may be used to enforce child support obligation pursuant to 13 *Del. C.* §2216 and for other lawful purposes.

3. Are you nationally certified as a Physician Assistant? Yes ( ) No ( )
If yes, please provide name of certifying agency, date of certification and certification number.

_____

If you have not passed a national certifying examination, please provide the date of the examination for which you are registered.

_____

If you have taken the national certifying examination and the results are pending, provide the date that you sat for this examination.

_____

5. Do you currently log appropriate continuing medical education (CME) with a nationally recognized agency? Yes ( ) No ( )

If yes, indicate the following certifying agency:
NCCPA ( )
AAPA ( )
Other ( )

If you checked "Other", indicate name of agency: _____

Is your CME current within the last two years (100 cumulative hours, 40 of which are Category I CME) as required by the Board of Medical Practice? Yes ( ) No ( )

SECTION III: LICENSURE VERIFICATION

1. Have you ever been denied a license or a registration to practice as a Physician Assistant? Yes ( ) No ( )

If yes, please provide an explanation on a separate sheet and attach it to this application.

2. Have you ever been granted licensure by a State or Territory? Yes ( ) No ( )

If yes, please list:

State or Territory	License Number	Expiration Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION IV: DISCIPLINARY ACTION INFORMATION

1. Have you ever been the subject of any disciplinary action (formal or informal) by any federal or state agency or any hospital credentials committee? Yes ( ) No ( )

2. Have you ever been convicted of or entered a plea of guilty or *nolo contendere* (no contest) to any felony, misdemeanor or any other criminal offense in any jurisdiction, including any offense for which you have received a pardon? If yes, submit a certified copy of your criminal history record. Yes ( ) No ( )

3. Have you ever been denied a DEA (narcotic) registration number? Yes ( ) No ( )

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS IN SECTION IV, PROVIDE A WRITTEN EXPLANATION AND ATTACH IT TO THIS APPLICATION.

SECTION V: HEALTH AND DISABILITY

1. Have you recently or within two years had a physical or mental disability which could reasonably be thought to interfere with your practice as a physician assistant, including use or abuse of dangerous or addicting substances? Yes ( ) No ( )

2. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? Yes ( ) No ( ) Not applicable ( )

   If yes, please explain on a separate sheet and attach it to this application.

3. Have you within two years engaged in the illegal use of controlled dangerous substances? If yes, please explain on a separate sheet and attach it to this application. Yes ( ) No ( )

4. Are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? Yes ( ) No ( ) Not applicable ( )

The Board office must receive items submitted for the Council to consider at its meeting no later than two full business days before the meeting. In order to be considered at a Council meeting, license applications must be <u>complete</u> two full business days before the Council meeting.

A <u>complete</u> application is one that includes all required documentation and correct payment. Applications that are not <u>complete</u> within six (6) months of filing may be considered abandoned and discarded. The Board office will attempt to notify you before disposing of an abandoned application.

Please note: When your application is <u>complete</u>, please allow 4-12 weeks to receive your permanent license.

AFFIRMATION

I, _____, the applicant named herein, do declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

I hereby consent to the release of any information by any person having such information, to the Delaware Board of Medical Practice regarding my education, background or qualifications to be licensed as a Physician Assistant, and understand that such information shall be used by the Board of Medical Practice in consideration of my application to practice in Delaware. I hereby release and hold harmless from liability any persons who in good faith provide such information to the Delaware Board of Medical Practice.

_____ _____

Signature of Applicant Date

Sworn and subscribed before me this _____ day of _____, 20_____.

_____

Notary Public

NOTARY SEAL/STAMP

TEMPORARY LICENSE

I wish to receive a temporary license pursuant to 24 Del. C. Section 1774 (a) as cited below.

"Notwithstanding any provision of this subchapter to the contrary, the Executive Director, with the approval of a physician member of the Board, may grant a temporary license to an individual who has graduated from a physician or surgeon assistant program which has been accredited by the Committee on Allied Health Education and Accreditation (CAHEA) of the American Medical Association (AMA) or a successor agency and who otherwise meets the qualifications for licensure but who has not yet taken a national certifying examination, provided that the individual is registered to take and takes the next scheduled national certifying examination. A temporary license granted pursuant to this subsection is valid until the results of the examination are available from the certifying agency. If the individual fails to pass the national certifying examination, the temporary license granted pursuant to this subsection must be immediately rescinded until the individual successfully qualifies for licensure pursuant to this subchapter."

I have read Section 1774(a) and agree to comply with the terms and conditions of being issued a temporary license.

_____ _____

Signature of Applicant Date